TB Treatment/Discharge Plan

2002A-TB-004

Patient Name	Gender ☐ M ☐ F	DOB	SSN
Address			Telephone
Occupation	Work Site		Work Phone
Emergency Contact	Address		Phone

TO BE COMPLETED BY THE TREATING PHYSICIAN OR FACILITY

Case reported to the local health department by: _____ on (date) _____

The TB care physician will be: _____

Physician Address _____ Phone _____

Other follow-up caregivers: _____
(name, agency, & phone)

TB-specific patient education and counseling has be done by _____ on (date) _____

Drugs and dosages prescribed Patient body weight _____ kg Estimated Date of Completion of Therapy: _____

☐ INH ____ mg ☐ RIF ____ mg ☐ PZA ____ g ☐ EMB ____ mg ☐ SM ____ g

☐ B-6 ____ mg ☐ other _____ ☐ other _____

To be ingested: ☐ daily ☐ 2x weekly* ☐ 3x weekly* * **DOT is required for intermittent regimens**

TB treatment will be: ☐ Directly Observed Therapy (DOT) ☐ Self-Administered Therapy (SAT) ☐ DOT and SAT

1st DOT appointment: _____ (date) _____ (time) _____ (place) ☐ LHD staff ☐ other: _____

Isolation Status: ☐ no isolation ☐ home isolation ☐ legal isolation

Person monitoring isolation : _____

Identify any treatment adherence obstacles:

☐ homelessness ☐ physical disability ☐ substance abuse: _____

☐ mental disability ☐ none ☐ other: _____

Identify any personal service needs:

☐ housing assistance ☐ food/nutrition ☐ local/state welfare ☐ child care ☐ transportation

☐ drug treatment ☐ mental health services ☐ home health services ☐ employment services ☐ none

☐ other: _____

Referrals for these needs were/will be made to: _____ on (date) _____

Other considerations/comments: _____

TO BE COMPLETED BY THE LHD AND PROVIDED TO THE PHYSICIAN / FACILITY

The assigned Public Health Nurse Case Manager is: _____ Phone: _____

Initial DOT visit will be made by: _____ (name)

The DOT worker(s) will be: _____ (name) ☐ health dept staff ☐ family member ☐ other

DOT will be done at _____ (address) ☐ home ☐ school ☐ work ☐ other
(Schedule to be established by DOT worker and patient at first visit. The patient will sign a DOT agreement that includes DOT instructions.)

Primary responsibility for contact investigation: ☐ case manager ☐ other _____

Proposed interventions for identified obstacles to adherence: _____

Other considerations/comments: _____

_____

The following individuals have been notified and approve of the above treatment plan:

☐ Attending physician _____ date _____

☐ Local Health Department _____ date _____

Patient signature: I have received instructions from my physician _____ date _____

☐ Patient elected not to sign: Discharge planner _____ date _____